Massachusetts Department of Public Health
Request for Restrictions on Use and Disclosures of Confidential Information

Name:_____

Address:_____

Phone # _____ Date of Birth: ___/ ___/ ___

REQUESTED RESTRICTION: Please describe the type of restriction you desire, and the programs to which your request applies. **Please note**: 1) Only the programs listed will be required to comply with this request. 2) DPH cannot agree to restrict disclosures required by law. 3) Even if your request is approved, disclosures to you will not be restricted.

_____

_____

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_____

My request applies to (check one and indicate date(s)):

[ ] Communications about this date only ___/ ___/ ___; or

[ ] From this date ___/ ___/ ___ until I indicate otherwise; or

[ ] From this date ___/ ___/ ___ to this date ___/ ___/ ___.

_____ ___/ ___/ ___

Your Signature or Signature of Personal Representative Date

_____

Print Name

Indicate relationship of person signing this form to the individual who is the subject of the information:

___ Person signing is the individual

___ Person signing is the Personal Representative authorized to make health care decisions for the individual. Describe the authority._____

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DPH Use Only

DPH Decision
[ ] Request Approved **[ ] Request Denied**

_____
_____
_____
_____
_____
_____

By:

_____
Signature Title Date

If a you have a complaint about this response you may file a complaint with:

Privacy Office
Massachusetts Department of Public Health
250 Washington St.
Boston, MA 02108
Phone: 617-624-6083